



GRIC Protecting Our Communities Addressing Domestic Violence, Child Violence, and Sexual Violence



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ABUSIVE HEAD TRAUMA: THE SCIENCE & THE LAW

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READING AND UTILIZING MEDICAL RECORDS

I HOSPITAL HIERARCHY

A. Types of Physicians

- Medical Director
- Head of Department (e.g., Peds, Surgery)
- Attending physician or hospitalist
- Forensic pediatrician/FNP/FPA (for child abuse)
- Fellow
- Chief Resident
- Senior Resident (usually 3rd year)
- Junior Resident (usually 2nd year)
- intern (first year)
- medical student

B. Which are actually licensed Dr's (MD's or DO's)?

- Attending physicians: responsible for supervision of residents and med students, licensed

Residents: In Peds, residency is 3 years; first years known as interns, by 3rd year, one will be designated Chief Resident; licensed

Med Students: Not licensed

C What is "house staff"

refers to doctors in training, to include residents, interns, medical students and fellows

Fellows generally have completed residency and are pursuing advanced training in a specialty

D. Why does this matter?

when you talk to a doctor to obtain patient information, ALWAYS determine and document the level of training. You want to talk to the most senior person available.

E. How do you know who is senior from reading progress or consultation notes?

PCH: See example

- Banner: See example

F. Nurses

-Nurses can provide basis information on status, but please refrain from asking them about diagnoses/prognosis/mechanism of injury

G. Common specialties consulted in child abuse cases (almost all have pediatric subspecialties)

- Surgery
- neurosurgery
- trauma surgery
- neurology
- radiology
- neuroradiology
- ophthalmology
- oncology
- gastroenterology

-orthopedics

IL TYPES OF MEDICAL DOCUMENTATION IN FILE

A. (varies with hospital)

B. Most common

1. History and Physical (H & P)

May be ER, Trauma, ICU

2. Progress Notes

These are daily assessments

3. Intensive Care Notes

4. Discharge /Death Summary

5. Radiology Reports

Chest xrays, other xrays, CT, MRI

6. Operative Report

If patient underwent any surgical procedures, this will tell you what was found, the extent and prognosis of the injury, and may discuss causality and may be important for timing. In most cases, it will be important to interview the surgeons to discuss the above issues.

7. Consultation Reports

Will be all specialties the treating doctor ordered

8. Outpatient Clinic Notes

May precede or follow hospitalization

9. Social Work Notes

These are very important for history.

10 Labs

Often are incorporated into daily progress notes

11. Orders

Let's you know what has been ordered re: meds, consults, additional testing, etc.

12. Respiratory records
These will show up in all intubated patients
13. OT, PT, Speech
14. Photos

III. MEDICAL EXAMINERS FILE

1. Autopsy Report

- main report
- neuropath report
- forensic anthropology report (fractures)
- toxicology
- microscopic examination: This is critical for assisting in dating the injuries, BUT you must interview the ME before trying to interpret them, as many things can influence healing of injuries.

2. Photos

3. Correspondence

4. Labs

IV. REQUESTING MEDICAL RECORDS

1. Utilize correct form, varies by hospital
 - PCH (see form)
 - Banner (see form)
 - Others: Generally use the PCH request form on peds cases in other hospitals, just change the name of the facility
2. EMS/FIRE/AMBULANCE/AIR EVAC
 - varies with the facility. Check with paralegals, if issues, see me

V. ELECTONIC MEDICAL RECORDS

1. What is an EHR (Electronic Health Report)

- increasingly all documentation is entered digitally, and written reports will be scanned
- Need to ask for all scanned documentation since they may not be included in the HER
 - this can include minute by minute code reports which can be critical information for the lawyers to know about
 - outside reports (e.g., EMT reports) may also be scanned.

2. When do I need to request them?

- social workers, nurses or medical records will often provide “on the spot” records to investigators, but these should NOT be used as the official records, since not everything is included in them (e.g., radiology reports)
- after death/discharge/ file a complete HIPAA compliant records request and ask for the entire record.

3. Where do I request them from?

- Any ER, Urgent Care or doctor’s office immediately prior to this hospitalization: you won’t get them from the admitting hospital
- EMS/Air Evac records
- Birth Records:
- Pediatric Records
- Any other ER/Urgent care you become aware of.

4. What form do I use?

Indian Health Services: Use the PCH form, adapted to IHS, to be signed by the lieutenant or Commander. You also need to use the Touhy letter along with request for interviews.

Other Hospitals and doctors: Adapt PCH form to reflect name of facility and what you want

VI. SORTING AND ANALYZING THE RECORDS

1. Start by separating the records into discrete categories (often the hospital has already done this for you). Make a list of categories, and place them in either primary, secondary or tertiary review lists.

VII. INITIAL ITEMS TO REVIEW: Initially, pull out the Discharge Summary, the H & P's, Consultation Reports (including operative reports) and radiology.

H & P

note attending physician...this may change if patient is admitted, but these are who you should aim to talk to-

note source of history: patient/one parent/both parents? Ask if they were together or interviewed separately. This can tell you who knew what and any differences in story.

Look at HPI (history of present illness):

this is the story the initial doctors got, who they got it from (NOTE: the problem with EMR's is that it is often a "cut and paste" situation, so even if the history changes, most doctors who are consulted will just copy the history from the H & P, unless they

spoke to the parents. Thus, do not assume the history written by a consultant is one they heard firsthand. You will later compare this to what was told to the EMT's, officers or DCS. Minor variations are to be expected, but major ones are not.

Look at PMH (prior medical history)

Any red flags? Hypoxic insult at birth (need med records, consider that this may be a defense later on since baby is only 9 weeks old)

-emergent c section at birth: impact? Use of forceps? Issues in the NICU or newborn nursery?

-transferred to NICU at PCH: need those records as well

seen yesterday: need records and see if there is any correlation to this admission

Meds taken at 10:55: need to ask how delivered, how child responded, fed at 1500...when was prior feeding? Remember to go back 3-5 days of history: feeding, stooling, eating, sleeping, what is normal for this child. Who feeds, how is it tolerated, child's normal level of alertness, interaction. Who else saw the child? Did they see anything unusual?

no family history of bleeding disorders: may be important as this is a common defense, no history of fractures, OI

Social: lives with M, F and 2 yo sibling (may blame a sibling)

Physical Exam:

anterior fontanelle full & open: often due to increased ICP, posterior fontanelle open (significance)

Eyes: suspicious for diffuse hemorrhages bilaterally (hopefully will get more documentation of this, if not, need to determine who examined the eyes to interview that doctor)

Bruises over chest: from what? Consistent with CPR? Was any done, and if so by whom? Training? Why did child need CPR in the first place?

Linear greenish bruising on L lateral thigh: this is a 9-week-old, non-mobile child, so this is highly suspicious. If child dies, you can do microscopics on the bruising to determine if healing has begun, but can't date by sight. Need caretakers and anyone who had contact with the child interviewed to see what they noticed and when.

Initial labs:

note those that are high or low. I can't interpret them, but make sure you ask doctor the significance of the labs. If you note them, note the H and L, as those are out of the norm

Diagnostic Radiology:

Chest: Evidence of healed left anterolateral and left posterior rib fractures in multiple locations, and possible healed right anterolateral fractures as well; need to ask radiologist how far healed? Difference between healing and healed? Significance of location as it relates to mechanism. For example, rib fractures consistent with history? Mechanism of lateral fractures? Presence of metaphyseal fractures? New fractures often don't show up (no callus yet) except on a bone scan, but healing fractures can be given a time frame (generic)...most show up at

about a week, and (add in callus information) Discuss difference with skull fracture healing and timing

Note: this is a 9-week-old with a C Section: need to look at birth records and possible x-rays done in the NICU to rule out birth trauma

Radiologist says to consider nonaccidental trauma: why?

Head CT/Brain

this is often the first indication of head/brain trauma. It is better than an MRI at showing acute cerebral edema during the first 12 hours after injury. An MRI is often ordered as a follow up. Read the conclusion first; that will give you an idea of what findings were seen.

hyperdense intracranial hemorrhage in the right parietal regions that appears to be parenchymal and possibly subarachnoid...parenchymal is the brain tissue itself. SAH, SDH are above the brain and below the skull; subscalpular and subgaleal are between the skull and the scalp (often not seen until autopsy).

Head CT showed large bilateral skull fractures, with bilateral intracranial hemorrhages: need to ask treating neurologist/neurosurgeon or pediatric specialist the significance of these. There is an expanding or temporal Cephalohematoma. Note that we can't date skull fractures per se, but there are scalp hematomas/bumps, external bruises, that might indicate recent injury)

Impression and Plan

This will give you your initial differential diagnosis, the things they are considering or trying to rule out. It will also give

you an indication of additional testing or consults they are planning on doing. If SNAT is in the diagnosis, fine, but it may not be. Either way, the potential diagnosis can help refute the defense that SNAT was the initial and only potential diagnosis considered.

Consultations

- tells you who, when and specialty, referring Dr.

- note a lot is a rehash of what she reviewed, so skip and go to physical exam, assessment and impression

Operative reports tell you what the surgeons saw in the operating room, the extent and prognosis of the injury, and may discuss causality and may be important for timing purposes.

VIII. SECONDARY REVIEW

Next, you will look at the following:

EMS records,

ER records

daily progress notes

labs

social work notes,

nursing notes.

EMS records

- gives first story told, condition of child, demeanor of parents. Make sure detectives interview them re: observations and statements of caretakers.

ER records

-may include the code, initial condition of child (important for timing)

Progress Notes:

-shows daily progress, don't waste time reading them in toto, just jump to assessment and plan, as that will summarize any changes

Labs:

-Metabolic bone labs: Ca, Phos, Alk Phos, Vitamin D, parathyroid hormone: useful for fractures

-Belly labs: ALT, AST, Amylase: show possible internal bleeding, BUT be aware that if child is in critical condition, all labs can be abnormal since the child is basically dying (even if he/she doesn't die)

-Bleeding labs: CBC with platelets. PT, PTT, Von Willebrands

Nursing Notes:

Look for narrative, as that will include any observations, ignore the daily wts, intake/output, etc.

Social Work Notes:

should include names of DCS/OCWI workers, history provided, any issues with family while in the hospital,

IX TERTIARY REVIEW

Flow charts, meds, nutrition, orders, respiratory, OT/PT, nutrition

IX SUMMARY

This analysis should give you an overview of what the injuries are, who you have to talk to/subpoena for trial, any preexisting issues that might complicate the diagnosis/proof of abuse.

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- ER records
- Admission H & P
- Consultation Notes
- Social work notes
- Discharge summary

Secondary review

- nurses notes
- progress notes
- diagnostic imaging
- operative reports

Not so important to review (put aside)

- flow charts
- medications
- lab reports
- nutrition
- orders